oxygen to the infant almost continuously on account of dyspnea and cyanosis. The baby's heart was good, and a flat x-ray plate was taken of the chest and abdomen. The radiologist at the Pasadena Hospital, Dr. John Chapman, made a diagnosis of diaphragmatic hernia. He confirmed his diagnosis with a barium meal with x-ray showing all of the small intestines and most of the large intestine in the right chest, completely collapsing the right lung, partially compressing the left lung and crowding the heart over to the left. The child's condition was so desperate that after consultation, it was decided, in order to save the baby's life, it would be necessary to operate immediately.

After obtaining the parents' consent, the baby was taken to the operating room and placed on the operating table. Having been laid on the left side, the position necessary for the operation, it collapsed and was resuscitated by means of carbogen under pressure. The heart action continued good, and an operation being the only chance the baby had, the operator was advised to proceed.

Through artificial respiration inflating the left lung by means of the McKesson machine, using 95 per cent oxygen and 5 per cent carbon dioxid intermittently, about five or six times per minute, the baby was kept alive, but without respiratory movements. The first incision was effected through the right pleura, and an attempt made to replace the intestines. Since this was impossible, an abdominal incision was made, and with difficulty the intestine was pulled down into the abdominal cavity. The hernia being thus reduced, the opening, 6 centimeters in length in the diaphragm, was closed with four mattress sutures. After the hernia was closed, it was possible to inflate both lungs and the baby's condition improved. The operation lasted over an hour, and the only anesthetic used was 95 per cent oxygen and 5 per cent carbon dioxid until the last five minutes, when the skin sutures were being placed. The baby was limp and perfectly relaxed, life being maintained by periodically inflating the chest with carbogen. While applying the skin sutures, anesthesia was obtained by giving 50 per cent carbogen and 50 per cent nitrous oxid. At the close of the operation, breathing was regular, the normal pink color was restored, and the baby returned to the nursery in good condition. Six days later an x-ray showed the chest naturally expanded, and the intestines normally placed in the abdominal cavity.

### CONCLUSIONS

1. In order to render the best possible service to the patient and the greatest assistance to the operator, in bad anesthetic risks it is necessary that a complete medical and surgical diagnosis be made prior to the operation.

2. The anesthetist must not only be trained in the mechanics of anesthesia, but must also be prepared to advise the surgeon as to the patient's condition at all times, and to anticipate complications in time to meet them.

605 Professional Building.

## DIAGNOSIS VERSUS TREATMENT*

### WITH REFERENCE TO DERMATOLOGY

*By* LOUIS F. X. WILHELM, M. D.
*Los Angeles*

IN all branches of medicine we are confronted with the importance of diagnosis as contrasted with method of treatment. It is true that the patient consults the doctor, as my former chief, Dr. Fordyce, often said, not to be handed a long Latin name which he cannot understand, but for relief of his complaint. In order that the physician may be able to give relief by intelligent treatment, he must not only be a good therapist, but a competent diagnostician. This is as true in the realm of skin diseases and syphilis as in any other field of medicine. We, who limit our endeavor to the diagnosis and treatment of skin diseases and syphilis, believe that a great many practitioners, without any attempt at diagnosis, divide skin lesions into two classes—those to which they apply calamin lotion, and those to which they apply zinc oxid ointment. And yet they claim to be physicians.

The difference between a regular physician and the cultist is in the scientific approach of the former, by reason of his knowledge of the fundamental sciences and his training in making a diagnosis. The physician who, without attempting to make a diagnosis other than skin-rash or eczema, prescribes calamin lotion or zinc oxid ointment, becomes a cultist in practice if not in name. He brings discredit upon himself, and adds to the ever-growing lack of confidence of the masses in the noble profession of the healing art. His action often serves to turn the patient from the regular physician to the cultist. Is it any wonder that the various cults thrive?

### INCORRECT DIAGNOSIS

It is not uncommon in these days for the general practitioner to suspect allergy in every type of generalized itching dermatosis. So-called allergy is considered the basis of every itching-skin eruption. The morphology of the individual lesion, and the distribution of the various lesions and their possible relationship to some systemic disturbance, is entirely disregarded. It is quite the rule, then, to refer the patient who complains of itching to the allergist who, of course, is not in position to give a competent opinion. After his numerous scratch and intradermal tests prove to be negative or positive, he is at sea as to further procedure in reaching a proper diagnosis. Hopkins recently again has pointed out the importance of physical disturbance, rather than food or protein allergy in chronic urticaria. Clinical interpretation often is more valuable than laboratory methods, especially skin tests, in a great many generalized itching dermatoses.

Moses Scholtz recently called attention to a patient who was studied for weeks, with all kinds of scratch tests and intradermal tests, when a

*Chairman's address, Dermatology and Syphilology Section of the California Medical Association, at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

diligent search for the burrow in the usual sites disclosed a typical scabies. Only a few days of antiscabetic treatment were necessary to give this patient complete relief, proving that skin tests were unnecessary.

Every dermatologist is familiar with the patient who is referred on account of a generalized eruption which has been treated vigorously for ringworm of the body by tincture of iodin, mercurochrome, mycosal, kerolysin, and a million and one other proprietaries, but which was in reality a typical pityriasis rosea. Also, there is the patient with early mycosis fungoides or leukemia cutis, treated for scabies, and the patient with parapsoriasis and pityriasis rubra pilaris who was referred to the dermatologist after he had submitted to the countless scratch and intradermal tests of our modern allergist.

More serious still is unrecognized syphilis. Recently I saw a man with typical syphilitic papules scattered generally over the body, and involving the face, palms and soles, who had been allowed to marry because two Wassermann tests on the blood were negative. Certainly, we all know that secondary syphilis gives 100 per cent positive Wassermann reactions on the blood. Suspecting that alcohol might account for the negative test, it was found, on questioning, that for years the patient never consumed less than a quart of bourbon whiskey per day. After three days of total abstinence, the Wassermann reaction proved the strongest total inhibition of hemolysis that the laboratory had recorded in ten years. The wife, incidentally, also presented a typical rosealar secondary lues.

A physician's nurse or secretary often is quite difficult to handle. Some years ago I saw a nurse with a very suspicious appearing ulcer on the breast and a typical satellite lymph node of Fournier, and advised a Wassermann test of the blood. Three or four weeks later she returned for further advice. In the meantime, she had consulted a surgeon who made a clinical diagnosis of Paget's disease and referred her to an exclusive x-ray clinic for treatment. When two deep x-ray treatments had failed to influence the lesion, she again requested my opinion before proceeding to surgery. After an extreme amount of persuasion, the patient finally submitted to a blood examination which disclosed a total inhibition of hemolysis. Adequate treatment for syphilis restored a normal breast and averted an unnecessary mutilating operation. A number of years ago I saw a patient who presented an ulcer of the right tonsil with the typical satellite lymph node of Fournier. He had been told that the lesion was a sarcoma. Repeated smears examined by the darkfield method disclosed typical *Spirochaeta pallida*. Examination of the blood gave a strongly positive Wassermann reaction. Adequate treatment for syphilis was followed by complete recovery.

Numbers of examples of undiagnosed late syphilis could be cited. For instance, a patient presented himself for relief of attacks of periodic vomiting, after having submitted to five exploratory laparotomies without improvement. The appendix and gall-bladder had been removed, and practically every abdominal organ had been studied macroscopically. Although blood Wassermann and spinal fluid examinations were entirely normal, a neurological examination disclosed typical findings of tabes dorsalis with gastric crisis. Thus, the five previous operations were proved to have been absolutely unnecessary.

I shall never forget the patient who was brought two thousand miles on a stretcher for medical aid, contrary to the advice of her family physician. She was found to have an infiltrating mediastinitis and pleuritis. Over a period of years, gradually she had become bedridden. Both her blood Wassermann and spinal fluid Wassermann reactions were strongly positive. Four months of active treatment for syphilis restored her powers of locomotion and caused an involution of all objective chest findings. This allowed her to return home and to walk unaided into her family physician's office, instead of being carried in as on her previous visit four months earlier. According to her own story, she asked him, "Why did you not test my blood and save me this 2000-mile journey?" A fair question, one must admit.

## IMPORTANCE OF CORRECT DIAGNOSIS

These few case references serve to emphasize the importance of correct diagnosis before treatment is instituted. They could be multiplied easily. Failure to give the patient intelligent advice and proper treatment was due to improper diagnosis. The physician who makes a correct diagnosis can give a reasonably accurate prognosis. He will not subject the patient to irrelevant skin tests, to unnecessary treatment with various glandular substances, to contraindicated x-ray therapy, or to uncalled for surgery. At times one is inclined to think that patients so mismanaged might have done as well in the hands of cultists!

It is important in these days of various cults and isms that we, as a profession, examine our own practices. Possibly some of the material success of the irregulars is due to the failure of graduates from the recognized schools of medicine to admit their limitations. If a physician is unable to make a positive diagnosis, the patient invariably will welcome the suggestion of having consultation. Unfortunately there are still a great number of our profession who prefer to treat the patient without knowing what they are treating. In this way, they do exactly as the cultist who is always ready to try his adjustments or colonic washings or inane diet. To practice scientific medicine, we must know what the condition is before we suggest or begin therapy.

Pusey emphasizes the importance of diagnosis in a recent editorial in the *Archives of Dermatology and Syphilology* on "Treatment by Method Rather Than Diagnosis." He says:

"There is no satisfactory way of treating cutaneous or other diseases without knowing what one is treating. It is not sufficient to be expert in radiology, serum therapy, balneotherapy, electrotherapy, heliotherapy or surgical technique, or in any other method of treatment. None of them is a panacea. One needs to know what one is treating. In diseases of the skin it is not even suffi-

cient to take a piece of tissue and submit it to a pathologist; in most cutaneous diseases the clinical diagnosis is needed also, and the clinical diagnosis is always important. That is where the radiotherapeutists fall down in the therapy of diseases of the skin; they do not know and cannot find out what they are treating, and they proceed blindly. Even if we agreed to the proposition that the radiotherapeutists should treat the malignant growths of the skin, and the dermatologists should treat the non-malignant ones, the radiotherapeutists would still need the dermatologist to tell them which was which. One cannot diagnose one kind of diseases of skin—malignant ones, for example—unless one knows the other kinds."

While Pusey emphasizes the fallacy of radiotherapy without correct diagnosis, what he says is equally true of all other methods of therapy when the physician does not know what he is treating.

1401 South Hope Street.

## RUPTURED ECTOPIC PREGNANCY*

*By* LEON J. TIBER, M. D.
*Los Angeles*

DISCUSSION *by Edward N. Ewer, M. D., Oakland; James C. Doyle, M. D., Los Angeles; R. Glenn Craig, M. D., San Francisco.*

THE material on which this paper is based consists of 248 cases of ruptured ectopic pregnancies treated in the Obstetrical Service of the Los Angeles County General Hospital from June, 1927, to December, 1932. These patients were operated on by the attending men of that service, and so the technique of the operations varies to a certain degree. However, definite rules and regulations laid down by the chiefs of that staff were observed in all cases.

As is well known, there has been nothing new found either in the symptomatology or the treatment of ectopic gestation in recent years except autohemofusion, which was used in 123 cases in this series. However, it may be of value to enumerate the symptoms and signs as found in this series of cases.

On reviewing the 248 cases, it was found that there was no uniformity of symptoms or signs, and Kelly's [2] dictum that the most typical thing about ectopic gestation is that it is atypical, is certainly borne out.

Whenever a woman in the childbearing period suffering from acute abdominal pain with uterine hemorrhage is examined, one must consider the possibility of an ectopic pregnancy. In this series some of the cases were mistakenly diagnosed as acute appendicitis, uterine fibroid, dysmenorrhea, abortion, pyosalpinx, ovarian cyst, menorrhagia, and acute upper abdominal conditions.

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.

TABLE 1.—*Age*

| Years | Percentage of Cases |
|---|---|
| .... – 20 | 3.4 |
| 20 – 25 | 22.3 |
| 25 – 30 | 27.3 |
| 30 – 40 | 41.2 |
| 40 – + | 2.9 |
| Not given | 2.3 |

TABLE 2.—*Para and Gravida*

| Para | Percentage of Cases | Gravida | Percentage of Cases |
|---|---|---|---|
| 0 | 23.9 | 1 | 17.2 |
| 1 | 25.5 | 2 | 17.8 |
| 2 | 18.3 | 3 | 17.8 |
| 3 | 11.7 | 4 | 12.2 |
| 4 | 6.1 | 5 | 12.2 |
| 5 – + | 7.2 | 6 | 6.8 |
| Not given | 6.7 | 7 – + | 8.9 |
| | | | 6.7 |

TABLE 3.—*Abortions and Miscarriages*

| Abortions | Percentage of Cases | Miscarriages | Percentage of Cases |
|---|---|---|---|
| 1 | 8.2 | 1 | 8.9 |
| 2 | 6.2 | 2 | 6.8 |
| 3 | 0.06 | 3 | 0.05 |
| 4 – + | 0.06 | 4 – + | 0.02 |

While there was no unanimity of symptoms and signs, still the following were found in most of the cases: some irregularity of menstruation, pains in the pelvis (with or without attacks of fainting), spotting or uterine hemorrhage of varying degrees, enlargement of the uterus (with or without a tender mass to any side of it), pain on moving of the cervix, pain on defecation, pain referred to the subscapular region, and distention of the pouch of Douglas, with signs of internal hemorrhage and shock. In this series the most frequent differentials to make were abortions, incomplete or complete, tubo-ovarian disease, salpingitis, ovarian cysts, and uterine fibroids.

TABLE 4.—*Types of Menstrual Disorders*

| | Number of Cases | Percentage |
|---|---|---|
| No missed periods | 85 | 34.2 |
| Missed period | 118 | 47.6 |
| Missed two periods | 40 | 16.1 |
| Missed three periods | 5 | 2.0 |

TABLE 5.—*Pain in Ectopic Pregnancies*

| | Number of Cases | Percentage |
|---|---|---|
| Sudden sharp pain with fainting | 75 | 30.2 |
| Sudden sharp pain without fainting | 120 | 48.4 |
| Sudden sharp pain after colicky pain | 61 | 24.6 |
| Colicky pain only | 50 | 20.2 |
| Shoulder pain | 77 | 31.0 |
| Shoulder pain not mentioned | 177 | 71.4 |
| No pain | 4 | 1.6 |